Organ commerce revisited

To the Editor: It may be time to revisit the issue of organ commerce. Early last September, the U.S. Internet auction site eBay closed bidding on a "fully functional kidney for sale" after it reached $5,750,100. In response to an about.com on-line poll conducted the following week, 69% of respondents thought it should be legal to sell one's own kidney.

In 1998, there were 2,307 deaths on the United Network for Organ Sharing (UNOS) kidney transplant waiting list [1]. These deaths are due to social obstacles in organ procurement, rather than scientific ones in transplantation.

Organ commerce is no new idea. India tried it for twenty years. In 1996, *Kidney International* published the article, "Commerce in transplantation in Third World countries" [2], which details many lessons learned in the absence of regulation. Among those, transplant donors were India's poorest and least healthy people, while their kidneys attracted the wealthy from around the world. Intermediaries commonly exploited donors by never paying them, and recipients never knew what they were getting for their money. They often got bad kidneys (records were falsified to show good HLA matches) and bad infections (for example, HIV, hepatitis).

A 1993 Gallup poll found that financial incentives would make 12% of respondents more likely to donate their own or their family member's organs, and that "younger respondents [whose organs are more likely to be viable] appear more amenable to financial incentives" [3]. These 12%, coupled with altruistic donations, could reduce deaths on the waiting list to zero. Perhaps UNOS could be trusted to screen, buy, and fairly allocate organs, as Rhodes suggests [4].

The Internet is changing the way medicine is practiced and perceived. Telemedicine consultations and a vast expanse of medical information is now available to patients. We need to be sure that patients are asking questions, and because technology and popular views on organ transplantation may be evolving side by side, we need to do the same.

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Comparison of survival data

To the Editor: In a recent issue of *Kidney International* Arkouche et al compare the survival data of their out-center patients (AURAL) with other series including ours [1].

The authors state that their population is comparable to the Tassin population for demography and age. We disagree. The highly selected population treated in self-care hemodialysis (HD) they describe is quite different from the global population we reported about in the two articles they refer to, which included over 75% of in-center patients. Comparing the AURAL to the Tassin overall population is misleading due to obvious selection bias. We have never published our out-center survival data (89, 77, 60, and 44% at 5, 10, 15 and 20 years, respectively).

Furthermore, opposite to usage, the authors describe a subgroup of 174 patients treated out-center but not accepted on the transplant list. This unconventional subgroup of patients with an "intermediate" risk level (that is, eligible for self-dialysis, but sick/old enough not to be considered for transplantation) cannot be compared with other series in terms of survival because such selection criteria have not been used up to now in published reports.

Arkouche et al must be congratulated for the excellent outcome their patients achieve, but nothing in their present data allows them to conclude that they achieve a better survival than others.

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Reply from the authors

We thank Dr. Charra and his colleagues for allowing us to expand on our out-center hemodialysis survival study [1].

We completely agree on the difficulties to compare

survival results between different structures. Based on their cardinal publication [2], the incidence of the high-risk etiologies of chronic renal failure (diabetes mellitus, systemic diseases, nephrosclerosis) was 20% in Tassin as compared with 22% in our population. The mean age at the start of treatment by hemodialysis increased in Tassin from 36.2 to 52.9 years, and from 31.2 to 52.6 years in AURAL. The table shows the age distribution:

	Age *years*					
	<35	35–44	45–54	55–64	>65	Total
AURAL	136	107	111	87	30	471
Tassin	112	84	111	98	40	445

In addition, we come to know in this letter that about 25% of the population analyzed by Dr. Charra were treated in out-center hemodialysis structures, yielding the comparison more difficult, and probably worsening their full-care in-center hemodialysis survival results. Therefore, we sincerely thank Dr. Charra for mentioning their unpublished out-center hemodialysis survival data that strongly support our conclusions, showing that out-center dialysis confers a better prognosis and should be encouraged.

Fortunately, more than 60% who started dialysis within our units were successfully transplanted, which appears to be a good rate among comparable dialysis units. This, of course, leads to a higher risk group of remaining dialysis patients. However, survival in this subgroup appears to be quite good and suggests that even those patients could benefit from out-center facilities.

Based on our data, we strongly recommend maintenance out-center hemodialysis for selected patients.

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